

# South West London and St George's Mental Health NHS Trust

## Quality Report

Building 28, Trust Headquarters  
Springfield University Hospital,  
61 Glenburnie Road,  
London  
SW17 7DJ  
Tel: 02035135000  
Website: [www.swlstg-tr.nhs.uk](http://www.swlstg-tr.nhs.uk)

Date of inspection visit: 27 - 28 September 2016  
Date of publication: 02/12/2016

Core services inspected	CQC registered location	CQC location ID
Community-based mental health services for older people	Trust Headquarters	RQYXX
Mental health crisis services and health-based places of safety	Trust Headquarters	RQYXX
Wards for older people with mental health problems	Springfield University Hospital	RQY01

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

# Summary of findings

## Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

### Overall rating for services at this Provider

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

### Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however, we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

# Summary of findings

## Contents

### Summary of this inspection

	Page
Overall summary	4
The five questions we ask about the services and what we found	5
Our inspection team	7
Why we carried out this inspection	7
How we carried out this inspection	8
Information about the provider	8
What people who use the provider's services say	9

---

### Detailed findings from this inspection

Findings by main service	11
Action we have told the provider to take	16

---

# Summary of findings

## Overall summary

After the inspection in September 2016, we have changed the overall rating for the trust from requires improvement to **good** because:

- In March 2016, we rated 7 of the 10 core services as good.
- In response to the September 2016 inspection findings, we have changed the ratings of one more core service from requires improvement to good. This is the core service for community based mental health services for older people.
- Also after the September 2016 inspection, we have changed ratings of the following key questions from requires improvement to good:
  - the effective key question for wards for older people with mental health problems,
  - and the effective domain for mental health crisis services.
- In the services we inspected, the trust had acted to meet the requirement notices we issued after our inspection in March 2016.

- We also carried out a 'well led' review and found that the trust had continued to strengthen its senior leadership team and refine the trust governance processes.

However:

- Following the March 2016 inspection, we rated two other core services as requires improvement. These are the rehabilitation wards for working age adults and community based mental health services for adults of working age. We also rated the safe domain as requires improvement for forensic services and child and adolescent mental health wards. The trust has provided clear action plans explaining the changes taking place over a longer timescale. The Care Quality Commission will return at a later date to re-inspect these services.

The full report of the inspection carried out in March 2016 can be found here at <http://www.cqc.org.uk/provider/RQY>

# Summary of findings

## The five questions we ask about the services and what we found

We always ask the following five questions of the services.

### Are services safe?

We rated safe as **requires improvement** because:

- In March 2016, we rated five of the 10 core services as requires improvement for safe. This led us to rate the trust as requires improvement overall for this key question.
- In September 2016 we inspected one of the core services rated as requires improvement for safe.
- We have changed the rating of safe for community mental health teams for older people from requires improvement to good. This is because the service had addressed the problems with how they manage and transport medicines that we identified during the March 2016 inspection. In March 2016, we found that in some staff did not always transport medicines to people's homes safely and the teams did not always keep a record of stock medicines. During this inspection we found the trust had made improvements in this area. A new lockable bag for carrying medicines had been introduced in all the teams. Staff kept accurate records of stock medicines held in the team medicine cupboards.
- We did not reassess the four remaining core services during the September 2016 inspection and so have not changed their ratings. This means that the rating for the trust for safe remains requires improvement overall.

**Requires improvement**



### Are services effective?

We rated effective as **good** because:

- In March 2016, we rated four of the 10 core services as requires improvement for effective. This led us to rate the trust as requires improvement overall for this key question.
- In September 2016 we inspected two of the core services rated as requires improvement for effective.
- When we inspected in March 2016, we found that many staff in the home treatment teams and in Crocus ward, an inpatient ward for older people with mental health problems, were not receiving individual managerial supervision on a regular basis. When we visited in September 2016, we found the trust had made a significant improvement in this area. Most staff were receiving regular one to one supervision. A new policy and system for recording and monitoring supervision had been introduced which was well liked by staff and effective.

**Good**



# Summary of findings

- This is a change of rating since the last inspection.

## Are services caring?

Good



- At the last inspection in March 2016 caring was rated as **good**. Since that inspection we have received no information that would cause us to re-inspect a core service or change the rating.

## Are services responsive to people's needs?

Good



We rated responsive as **good** because:

- In March 2016, we rated three of the 10 core services as requires improvement for responsive. This led us to rate the trust as requires improvement overall for this key question.
- In September 2016 we inspected one of the core services rated as requires improvement for effective.
- At the last inspection in March 2016, we found that the administration support for the Kingston community mental health teams for older people team did not ensure that appointment letters were reaching patients and GPs in a timely manner. The information needed to deliver care, was not always available to staff when they needed it. At the current inspection we found that the administration system that had been introduced shortly before the last inspection had improved and the systems were starting to be embedded across the trust. Letters to patients regarding appointments and to GPs were being sent out in a timely manner. The administration system was being rolled out across the trust.
- This is a change of rating since the last inspection.

## Are services well-led?

Good



We rated well-led as **good** because:

- At the last inspection well-led was rated as **good**. At this inspection we completed a 'well led' review and we found that the trust had continued to strengthen its senior leadership team and refine the trust governance processes. The rating remained good.

# Summary of findings

## Our inspection team

Our inspection team was led by:

**Team Leader:** Jane Ray, Head of Hospital Inspection (mental health) Care Quality Commission

The team included a CQC inspection manager, two CQC inspectors and a specialist advisor who was a senior mental health nurse manager.

## Why we carried out this inspection

We undertook this inspection to find out whether South West London and St George's Mental Health NHS Trust had made improvements to their community based mental health services for older people; mental health crisis services and health-based places of safety; and wards for older people with mental health problems since our last comprehensive inspection of the trust that we undertook in March 2016 where we rated the trust as **requires improvement** overall.

When we inspected the trust in March 2016, we rated community-based mental health services for older people as requires improvement overall. We rated this core service as requires improvement for safe, good for effective, good for caring, requires improvement for responsive and good for well-led.

Following the March 2016 inspection, we told the trust it must take the following actions to improve community based mental health services for older people:

- The trust must ensure good medicines management practice, ensuring the safe transportation of medication between the team bases and patients' homes and keeping a record of medicine stock levels.
- The trust must ensure the Kingston team has effective administration support. This is to ensure that all letters are sent to patients and GPs in a timely manner, and information needed to deliver care is stored securely and available to staff when they need it

Following the March 2016 inspection we rated mental health crisis services and health-based places of safety as good overall. We rated this core service as good for safe, requires improvement for effective, good for caring, good for responsive and good for well-led.

Following the March 2016 inspection, we told the trust it must take the following action to improve mental health crisis services and health-based places of safety:

- The trust must ensure that an individual 1:1 supervision structure is embedded in the home treatment teams and that staff have access to regular individual supervision.

Following the March 2016 we rated wards for older people with mental health problems as good overall. We rated this core service as good for safe, requires improvement for effective, good for caring, good for responsive and good for well-led.

Following the March 2016 inspection, we told the trust it must take the following action to improve wards for older people with mental health problems:

- The trust must ensure that staff on Crocus ward have access to regular 1:1 supervision.

We issued the trust with four requirement notices that affected these three core services.

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014: regulation 12 safe care and treatment, regulation 17 good governance and regulation 18 staffing.

The trust was inspected in March 2014 as a pilot for the Care Quality Commission's new inspection methodology. At this time trusts were not rated. In May 2015 a focused inspection took place across the acute and older person's inpatient services. This identified a number of areas of non-compliance at Springfield and Tolworth Hospitals. This was followed up as part of the March 2016 comprehensive inspection and all the previous areas of non-compliance

# Summary of findings

had been addressed. Just prior to the comprehensive inspection there was also a separate inspection of the specialist ward for deaf people and previous non-compliance had also been addressed on this ward.

The current inspection took place four months after the publication of the comprehensive inspection report (in June 2016). We have re-rated the three core services that were the subject of this most recent focused re-inspection .

## How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about South West London and St George's Mental Health Trust and asked other organisations for information. We carried out short notice announced visits on 27 and 28 September 2016.

We looked at information provided to us on site and requested additional information from the trust both immediately before and following the inspection visit relating to the services.

We also carried out a 'well led review' to look at any changes that had taken place in the leadership and governance of the trust since the previous inspection and to assure ourselves the trust was still well led. This also involved receiving feedback from external stakeholders.

We also made a number of recommendations at the last inspection which is where we think the trust should take actions to improve services. These will be followed up at a future inspection.

During the inspection visit, the inspection team:

- visited Crocus ward an inpatient ward for older people with mental health problems
- visited the home treatment teams in Kingston, Richmond, Wandsworth and Merton
- visited community mental health teams for older people in Kingston, Richmond and Merton
- held a focus group with ten managers and clinicians from the older people's community mental health teams to discuss administration support
- held a focus group with five administration staff from the Kingston hub to discuss administration systems
- spoke with the managers for each of the teams
- spoke with 32 other staff members; including doctors, nurses, nurse practitioners, health care assistants, a modern matron and recovery and support workers
- reviewed the arrangements for managerial supervision of staff
- checked the arrangements for transporting medicines and recording stock medicines in the community teams.
- Interviewed members of the senior executive team including the chief executive, chief operating officer and director of nursing.

## Information about the provider

South West London and St George's Mental Health NHS Trust provides services to a population of over 1.1 million people. The trust supports adults, older people and children and young adults across the five London boroughs of Richmond, Wandsworth, Kingston, Merton and Sutton. They also provide a number of specialist services for

people who are deaf, services for people who have obsessive compulsive disorders as well as forensic and eating disorder services. People using these services come from across the UK.

The trust employs over 2000 staff who provide inpatient and community care. Last year the trust had over 410,400

## Summary of findings

patient contacts. The trust has 408 inpatient beds located on three sites, Springfield University Hospital, Queen Mary's Roehampton and Tolworth Hospital. It has an annual budget of approximately £160 million.

The trust was organised into three borough based directorates, a CAMHS directorate and one specialist directorate and each had a clinical and service director. At the time of the inspection the trust was in the application pipeline to be a foundation trust.

## What people who use the provider's services say

We did not speak with patients during this inspection as the focus was on particular concerns in particular services

that were identified at the comprehensive inspection in March 2016. During the inspection in March 2016 there was significant patient engagement and we received considerable feedback from patients and carers.

# South West London and St George's Mental Health NHS Trust

## Detailed findings

# Are services safe?

By safe, we mean that people are protected from abuse\* and avoidable harm

\* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

## Summary of findings

## Our findings

### Assessing and monitoring safety and risk

- At our last inspection in March 2016 we identified that in some community mental health teams for older people staff did not always transport medicines to people's homes safely and the teams did not always keep a record of stock medicines.
- During this inspection we found the trust had made improvements in this area. A new lockable bag for carrying medicines had been introduced in all the teams and was used by staff when they took medicines to patients' homes. Staff in the home treatment teams kept accurate records of stock medicines held in the team medicine cupboards.
- However, the rating for safe remains requires improvement because there are further improvements the trust needs to make in other core services, which we did not follow up at this inspection. We will be following these up at future inspections.

## Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

### Summary of findings

## Our findings

### Skilled staff to deliver care

- At our previous inspection in March 2016 we identified that many staff in the home treatment teams and in Crocus ward, an inpatient ward for older people with mental health problems, were not receiving individual managerial supervision on a regular basis.
- During this inspection we found the trust had made a significant improvement in this area. A new supervision

policy and method for recording individual supervision had been introduced. Staff had received training in the new policy. The new system was well liked by staff. Some nurses felt that the focus on supervision recognised the importance of their role and professional development needs. On Crocus ward staff felt that an overall increase in staffing levels had made it easier to attend individual supervision on a regular basis. The time for supervision was considered 'protected' and ensured that it went ahead as planned

- In the four weeks prior to inspection, the home treatment teams had achieved an average supervision compliance rate of 81%. The supervision compliance rate on Crocus ward in the four weeks preceding the inspection averaged 95%.

## Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

### Summary of findings

### Our findings

- At the last inspection we rated caring as **good**. Since that inspection we have received no information that would cause us to re-inspect a core service or change this rating.

# Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

## Summary of findings

### Our findings

#### Planning and delivery of services

- At our last inspection in March 2016, we found that the administration support for the Kingston community mental health teams for older people team did not ensure that appointment letters were reaching patients and GPs in a timely manner. The information needed to deliver care, was not always available to staff when they needed it.
- At the current inspection we found that the administration system that had been introduced shortly before the last inspection had improved significantly. Letters to patients regarding appointments and correspondence to GPs were being sent out in a timely manner and could be easily located on the system. The teams had consistently achieved their targets to send out correspondence on time.
- The new administration system was being rolled out across the trust.

## Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

### Summary of findings

## Our findings

### Good governance

- The trust had continued to monitor the progress of the action plans following the last comprehensive inspection in March 2016. This had taken place through a recently established integrated governance group chaired by the director of nursing. This reported to the quality and safety assurance committee which was a sub-committee of the board.
- The trust had also recognised the need to strengthen the assurance for the ongoing work to ensure restrictive practices are carried out appropriately across the trust. It had established a trust wide restrictive practices governance group which reported quarterly to the quality and safety assurance committee.
- We heard that the trust was also making more proactive use of risk registers to ensure risks were shared from ward and team level to board.

- The trust was also reviewing the board performance and quality report, learning from good practice from other trusts.
- Overall the trust was making changes to further strengthen governance processes which were found to be good at the previous inspection.

### Leadership and culture

- At the time of the last inspection a permanent director of nursing had been appointed in March 2016 and had joined the trust in May 2016. The director of finance and performance had continued to be covered on an interim basis. This person had been in this role since February 2016 to provide continuity. One non-executive director had retired and another board member had taken over chairing the audit committee.
- The trust had an ongoing stable leadership team which was found to be good at the previous inspection. Feedback from external stakeholders expressed confidence in the leadership of the trust.
- The leadership team was working closely with other South London trusts to improve the care for patients, look at areas for effective sharing of resources, develop opportunities for staff training and also as part of a national pilot to develop new models for forensic services.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care <b>Rehabilitation mental health wards</b> On some wards patients were not receiving appropriate care to support their recovery and rehabilitation and meet their needs The trust did not ensure that the operational policies promoting rehabilitation were implemented on all the wards. This included providing a range of therapeutic activities that supported people with their rehabilitation. This was a breach of Regulation 9(1)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment <b>Care and treatment was not provided in a safe way and the trust did not do all that was reasonably practicable to mitigate the risks.</b> <b>Rehabilitation mental health wards</b> The trust had not ensured that all risks identified in risk assessments had associated plans to mitigate this risk.  Community based mental health services for adults of working age Care and treatment must be provided in a safe way for patients The trust did not ensure that individual patient risk assessments were updated to reflect current risk.

This section is primarily information for the provider

## Requirement notices

The trust did not ensure there are safe systems for the administration, storage and transportation of medication.

This was a breach of Regulation 12 (2)

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment  
**Forensic inpatient wards**

Service users were not protected from abuse and improper treatment because the provider operated restrictive practice with the use of time management practices, which had not been recognised as seclusion practices. Patients subject to these practices did not meet the safeguards set out in the MHA Code of Practice.

**Child and adolescent mental health wards**

Service users were not protected from abuse and improper treatment because the provider operated practices, which had not been recognised as seclusion practices. Patients subject to these practices did not meet the safeguards set out in the MHA Code of Practice.

This was a breach of Regulation 13(5)(7)

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

**Community based mental health services for adults of working age**

Systems or processes must be established and operated effectively

This section is primarily information for the provider

## Requirement notices

Changes in the configuration of teams, meant that team managers were not always receiving performance information that related correctly to their current team.

This was a breach of Regulation 17(1)

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing  
Rehabilitation mental health wards

The trust had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced staff being deployed and that they had the appropriate supervision and support to enable them to carry out their duties they are employed to perform.

The trust had not ensured that staff were receiving regular supervision to enable them to carry out their role.

The trust had not supported the managers to be effective leaders to implement a recovery-orientated approach across all the rehabilitation services.

Community based mental health services for adults of working age

Staff need to receive appropriate support , training and supervision to enable them to carry out the duties they are employed to perform

The trust had not ensured that staff were receiving regular supervision to enable them to carry out their role.

This was a breach of Regulation 18 (2)(a)